PRINTED: 09/13/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING _____ B. WING _____	C 09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification/Abbreviated Survey was conducted 08/30/10 through 09/01/10. Deficiencies were cited with the highest Scope and Severity of a "F". A Life Safety Code Survey was conducted 08/31/10 with no deficiencies cited. ARO KY00014927 was unsubstantiated with no deficiencies cited.	F 000	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly.	
F 281 SS=F	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure services arranged by the facility met professional standards of quality. The facility failed to ensure nurses were knowledgeable regarding their role in the event of an emergency which would necessitate the need for cardiopulmonary resuscitation (CPR), and failed to ensure staff were aware of the facility Policy and Procedure for "Care of the Unresponsive Resident and Cardiopulmonary Resuscitation (CPR)". The findings include: Review of the facility's Policy and Procedure for Care of the Unresponsive Resident and CPR revealed a detailed inclusion of the specific procedure to be followed in a Code Blue (establish lack of pulse, respirations, establish if the involved resident is a full code, send for crash cart, etc).	F 281	This Plan of Correction is submitted to meet requirements established by State and Federal law. F281 It is the policy of the facility to ensure services provided or arranged by the facility meet professional standards of quality. 1. LPN #2 was re-educated on the evening of 8/30/10 on the proper procedures for a "Code Blue" response at the campus.	10/2/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Stanmore TITLE: DHA (X6) DATE: 10-18-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/13/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING _____ B. WING _____	C 09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 1 On 08/30/10 at 11:00 AM, at the initiation of interview, Licensed Practical Nurse (LPN) #2 revealed she did not know where the crash cart was located. LPN #2 indicated that if encountered a resident on the unit with no observable pulse or respirations she would run to the adjoining unit to "get the RN". Further interview revealed the LPN was trained as to the facility's procedure for initiating CPR but did not recall the specifics of the training. Continued interview revealed LPN #2 started her employment at the facility on 07/26/10. During the above interview LPN #2 failed to demonstrated knowledge regarding her role as a nurse in the event of an emergency and was unaware of the facility's Policy and Procedure for "Care of the Unresponsive Resident and cardiopulmonary resuscitation (CPR)". Interview on 08/30/10 at 11:30 AM, with the Director of Nursing (DON) revealed the location of the facility crash cart to be in the supply room of the Health Care Services Unit. Further interview revealed nurse orientates received a tour of the building by the Nurse Mentor, which included the location of the crash cart and the location of the containers which held resuscitative equipment. The DON indicated the containers of resuscitative equipment were located on each additional unit of the facility; the Alzheimer Unit and the Extended Care Unit. Interview on 08/31/10 at 9:15 AM, with the Staff Development Coordinator/Assistant Director of Nursing (ADON), revealed her responsibility in orienting and renewing education for CPR was to	F 281	2. All licensed nursing staff and certified staff were educated by the Executive Director, Director of Health Services and Assistant Director of Health Services on the proper procedures for a "Code Blue" response. The in-service was completed by 9/30/10. The in-service addressed the policy and procedure for a "Code Blue" response at the campus. 3. The facility has updated the orientation checklist for both Licensed Nurse and Certified Staff to include "Code Blue". The orientation checklist is attached to the Plan of Correction. Licensed Nurse Mentors were re-educated by Assistant Director of Health Services as to the training expectations for licensed nurses. This training completed by September 30, 2010.	

PRINTED: 09/13/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING _____ B. WING _____	C 09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 2 ensure all nurses were CPR certified upon the hire date and to make arrangements for their re-certification, when it was due. Further interview revealed all employees were instructed on, and given a color coded designation of emergencies which was placed on the back of their name badges. She further stated, the facility's emergency designation for CPR was Code Blue. Continued interview revealed the facility policy and procedure for Code Blue and the nurses' role for Code Blue was supposed to be communicated to them by the Nurse Mentor. Interview on 08/31/10 at 10:00 AM with Registered Nurse/(RN) #3, who was the facility's Nurse Mentor for all newly employed nurses, revealed her responsibility regarding Code Blue was to familiarize the nurses with the resuscitative equipment. Further interview revealed she thought it was the Staff Development/ADONs responsibility to educate the nurses on their role in a Code Blue. Further interview with the Administrator on 08/30/10 at 10:00 AM, revealed LPN #2 received her LPN license in the past six (6) to nine (9) months. The Administrator indicated she thought it was unacceptable for a nurse or any direct patient care staff to be unknowledgeable of their tasks and responsibilities in a Code Blue. Interview with the Staff Development Coordinator/ADON on 09/01/10 at 9:15 AM, revealed LPN #2 was stationed on the Alzheimers Unit, where three (3) of the thirteen (13) residents on this unit were a Code Blue status. The ADON stated the staffing pattern on this unit (Alzheimers Unit) was one nurse per shift.	F 281	Upon completion of the orientation checklist for licensed staff, the DHS and/or ADHS will review "Code Blue" procedures with the staff member. If employee does not demonstrate sufficient knowledge, the new staff member will be re-educated and the Nurse Mentor will be re-educated as to the proper procedures for the training and the "Code Blue". 4. Additional measures the campus will initiate are quarterly "Code Blue" drills to be conducted by the Executive Director, Director of Health Services and Assistant Director of Health Services. Results of the "drill" will be discussed as part of the Quality Assurance meetings and any opportunities for staff improvement will be addressed immediately with re-education and training. Additionally, the Director of Health Services and/or Assistant Director of Health Services will conduct monthly "Code Blue" audits of staff knowledge with 10% of licensed staff and certified staff until 100% compliance.	

PRINTED: 09/13/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING _____ B. WING _____	C 09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 3 Review of LPN #2's facility employment records revealed she received CPR certification in October 2009 and was due for re-certification in October 2011. Review of the facility's Orientation Program Checklist for Nurses revealed no indication this policy was read, or understood. Further review of the Checklist revealed no indication the employee was given the opportunity to ask questions regarding the policy. Review of the facility's Orientation Program Checklist for Certified Nurses Aides (CNAs) revealed the same. (Nurses and CNAs were the direct caregivers at facility). Continued interview with the Staff Development Coordinator/ADON on 09/01/10 at 9:15 AM, revealed these checklists did not refer to the facility's Code Blue policy, and the orientation checklists needed to be more specific in documenting the facility's direct caregivers' familiarity with the Code Blue procedure.	F 281	Upon 100% compliance, the "Code Blue" audits will be conducted quarterly with results reviewed as part of the Quality Assurance meetings. If at anytime 100% compliance is not achieved upon review of the audits, the QA committee will implement monthly "Code Blue" audits and or drills to ensure staff knowledge until 100% compliance. Upon return to 100% compliance, the QA committee will re-implement quarterly audits. The facility alleges compliance as of October 1,2010.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, it was	F 371	F 371 It is the policy of this campus to ensure proper storing/preparing and serving of food.	10/2/10

PRINTED: 09/13/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING _____ B. WING _____	C 09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 4 determined the facility failed to ensure food was served under sanitary conditions. The findings include: Observation on 08/30/10 at 10:00 AM during the initial tour of the kitchen, revealed two (2) dented cans of food on the canned food rack. Interview with the Director of Food Services on 08/30/10 at 10:00 AM revealed the cans should not have been there; they should have been moved to the area designated for dented cans to be picked up by the supplier. Also on the initial tour of the kitchen on 08/30/10 at 10:15 AM it was revealed a wet mop was stored on the floor of the maintenance closet in the kitchen. Interview with the Director of Food Services on 08/30/10 at 10:15 AM revealed the Chef had just used the mop and put it in the closet without hanging it up and the mop should have been hung up to dry. Interview with the Chef on 09/01/10 at 1:45 PM revealed that he or she thought it was better to put the mop on the floor than have it wet and dripping if hung up. Observation on 08/30/10 at 12: 25 PM during tray line service, in the kitchen, revealed an aide came into the food service area without a hair restraint. Interview with the Dietary Manager on 08/30/10 at 12:26 PM revealed the aide should not have come that far into the kitchen without a hair restraint and should have been trained on wearing a hair restraint in the food preparation area. Interview with the Executive Director of the facility on 08/31/10 at 3:30 PM revealed she also observed the aide not wearing the hair restraint in the food preparation area. The Executive Director revealed the aide had been trained on	F 371	1. The dented cans identified during the initial tour were immediately removed from the rack. The mop identified during the initial tour was hung up properly immediately upon identification of deficient practice. The staff member observed to enter kitchen without a hair net was immediately counseled by the Executive Director as to the proper standards for entering the kitchen with a hair restraint. All other cans were observed to have no dents and no other mops were improperly stored. 2. The Director of Food Services conducted an in-service with facility staff to address wearing proper hair restraints and dietary sanitation when entering the kitchen. The in-service was completed by 9/30/10. Additionally, the Director of Food Service conducted an in-service with all dietary staff which addressed proper sanitation procedures for entire kitchen. Sanitation audit completed by Home Office Dietary Support Staff on 10/1/10 indicated compliance with dietary sanitation standards and regulations.	

PRINTED: 09/13/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185146	A. BUILDING _____ B. WING _____	C 09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 5 the requirement of the hair restraint but was new and just forgot. The Executive Director stated she had reminded the aide of the sanitation policy.	F 371	3. The Director of Health Services and/or the Executive Director will conduct monthly audits utilizing audit forms to observe for proper dietary sanitation procedures. Additionally, when Home Office Support staff visit monthly, they will complete a Dietary Sanitation Audit. The results of the audits will be discussed as part of the Quality Assurance meeting. Any opportunities for improvement will be addressed immediately with staff education. The audits will continue monthly as part of the QA program.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F 431 It is the policy of this campus to ensure proper storing and labeling of drugs and biologicals. 1. The debris and spillage identified during the observation of the medication room was cleaned immediately. The expired lancets were discarded immediately on 8/30/10. The cabinet drawer was cleaned immediately with all items discarded appropriately. Additionally, the expired irrigation tray was removed immediately on 8/30/10. Refrigerator was checked for cleanliness and all other supplies checked for expired dates, with none noted.	10/2/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING _____ B. WING _____	C 09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E . CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to ensure drugs and biologicals were labeled and stored in accordance with the currently accepted professional principles. Lancets and an irrigation tray were observed to be accessible to staff past the expiration date. The findings include: Observation of the Skilled Unit medication room on 08/30/10 at 4:20 PM revealed there were spills and debris in the refrigerator and freezer. In addition, the medication room had a box of fingerstick lancets with an expiration date of 01/20/10 in the cabinet, and a sleeve of medication cups in the cabinet drawer which also contained a used hair brush and a used comb. Observation of the supply room on the Skilled Unit on 08/30/10 at 4:30 PM revealed an irrigation tray with piston syringe with an expiration date of 08/07. Interview on 08/30/10 at 4:30 PM with Kentucky Medication Assistant (KMA) #1 revealed the refrigerator and freezer needed cleaning. She was unaware of who was responsible for cleaning the refrigerator or who was responsible for checking for expired supplies. Interview on 09/01/10 at 1:25 PM with the Assistant Director of Nursing (ADON) revealed she was unsure who was responsible for cleaning	F 431	There were no used items noted in the cabinets. All medication carts were audited for compliance with no expired medications noted. There were no additional deficient practice identified. 2. The Assistant Director of Health Services addressed with 3rd Shift nursing staff the responsibility for ensuring the medication room/medication cart/ refrigerator and IV supplies are to be maintained in acceptable infection control practices at all times and discarding of outdated supplies. The medication room and IV supply will be monitored weekly for compliance by the Director of Health Services and/or designee. An audit will be conducted on all medication carts to ensure compliance. These audits will be conducted weekly. These audits will be conducted by the Director of Health Services/ or Designee. The Medication Aides were re-educated by the Assistant Director of Health Services to monitor the medication rooms and maintain proper infection control practices and discarding of outdated items including items located on the medication cart. The in-service completed by 9/30/10. 3. The results of the weekly audits will be reviewed during the Quality Assurance meetings and any opportunities for improvements will be addressed immediately through the process of staff education and in-servicing. This education will be provided by the Director of Health Services and/or designee. Weekly audits of the medication room/medication cart and IV supplies will continue weekly for 3 months until 100% compliance and at 3 months, will be conducted monthly as part of the QA process. If at anytime 100% compliance not obtained, audits will return to weekly for 3 months or until 100% compliance on audits.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING _____ B. WING _____	C 09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 7 the medication refrigerator or who was responsible for removing expired supplies from the medication room or the supply room.	F 431	F 441 1. The employee identified as providing deficient practice was re-educated upon notification during the survey process.	10/2/10
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	Additionally, the Assistant Director of Health Services re-educated the employee on the policy and procedure for handwashing at the campus. 2. The Assistant Director of Nursing and Executive Director provided re-education to certified and licensed staff about proper standards and policy and procedure for handwashing and proper procedures for infection control related to feeding residents and facility infection control policy. In-service completed by 9/30/10. Audit was conducted on 9/29/10 with no deficient practice noted. An audit was conducted to observe for proper handwashing procedures during meal service; transporting of clean/dirty linens; before and after direct resident care and medication administration. No additional deficient practices were identified. Audit was completed by 9/30/10. 3. The Director of Health Services and/or designee will conduct audits during meal service, transporting of clean/dirty linens; before/after direct resident care and any other areas related to proper infection control practices. The audits will be conducted monthly x 3 months until 100% compliance is achieved. Upon completion of 100% compliance, the audits will be conducted quarterly. If at anytime during the audit observation deficient practice is identified, the staff member will be re-educated immediately and have to resign the policy and	
	(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of			

PRINTED: 09/13/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING _____ B. WING _____	C 09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 8 Infection. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to maintain an effective infection control program in order to prevent the development and transmission of disease and infection within the facility for one (1) unsampled resident of eleven (11) sampled residents (Resident #12). Resident #12 was noted to fed a sandwich, by an aide, with bare hands. The findings include: Observation on 08/30/10 at 5:30 PM, revealed Certified Nursing Assistant (CNA) #7 was feeding unsampled Resident #12 a chicken sandwich with her bare hands in the restorative dining room. There was no evidence the CNA used utensils to feed the resident the chicken sandwich. Interview on 08/31/10 at 3:30 PM with CNA #7 revealed she usually fed the residents sandwiches with a fork. She stated she had received training related to feeding at the facility and was taught to use utensils to feed the residents. Continued interview revealed she was usually in the main dining room for meals where the residents fed themselves, and was not used to feeding residents who needed more assistance in the restorative dining room.	F 441	procedure for proper handwashing and infection control practices. All results of the audits will be reviewed as part of the Quality Assurance Committee monthly meetings Upon identification of new infection, the Director of Health Service and/or designee will conduct random return demonstration audits among licensed staff to observe for proper infection control practices. Audit will be conducted on 10% of licensed staff. If 100% compliance, audit will be complete. If less than 100%, another 10% of licensed staff will be audited until 100% compliance achieved during observation of demonstration. Results of the QA audits will be reviewed during the monthly QA meetings. Additionally, the Director of Health Services and/or Designee will conduct staff re-education on the facility infection control policy and procedures. The Director of Environmental Services will maintain a Deep Cleaning Schedule of resident rooms and corridors to ensure proper infection control practices. DES will produce copy of completed schedule during the monthly QA meeting to ensure compliance. Facility infections will be reviewed monthly as part of the QA meeting. The report will be generated from the weekly DHS report which identifies all infections.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING 02 - CEDAR RIDGE HEALTH C B. WING _____	08/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A standard Life Safety Code survey was conducted on August 31, 2010. The facility was found to be in substantial compliance with Title 42, Code of Federal Regulations, 483.70(a) relating to NFPA 101 Life Safety Code 2000 Edition, with no regulatory violations identified on the date of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.